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The Doctor Won't See You Now. He's Clocked Out

ObamaCare is pushing physicians into becoming hospital employees. The results aren't encouraging.

By SCOTT GOTTLIEB

Big government likes big providers. That's why ObamaCare is gradually making the local doctor-owned medical practice a relic. In the not too distant future, most physicians will be hourly wage earners, likely employed by a hospital chain.

Why? Because when doctors practice in small offices, it is hard for Washington to regulate what they do. There are too many of them, and the government is too remote. It is far easier for federal agencies to regulate physicians if they work for big hospitals. So ObamaCare shifts money to favor the delivery of outpatient care through hospital-owned networks.

The irony is that in the name of lowering costs, ObamaCare will almost certainly make the practice of medicine more expensive. It turns out that when doctors become salaried hospital employees, their overall productivity falls.

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ObamaCare's main vehicle for ending the autonomous, private delivery of medicine is the hospital-owned "accountable care organization." The idea is to turn doctors into hospital employees and pay them flat rates that uncouple their income from how much care they deliver. (Ending the fee-for-service payment model is supposed to eliminate doctors' financial incentives to perform extraneous procedures.)The Obama administration also imposes new costs on physicians who remain independent—for example, mandating that all medical offices install expensive information-technology systems.

The result? It is estimated that by next year, about 50% of U.S. doctors will be working for a hospital or hospital-owned health system. A recent survey by the Medical Group Management Association shows a nearly 75% increase in the number of active doctors employed by hospitals or hospital systems since 2000, reflecting a trend that sharply accelerated around the time that ObamaCare was enacted. The biggest shifts are in specialties such as cardiology and oncology

Estimates by hospitals that acquire medical practices and institutions that track these trends such as the Medical Group Management Association show that physician productivity falls under these arrangements, sometimes by more than 25% (more on this below). The lost productivity isn't just a measure of the fewer back surgeries or cardiac catheterizations performed once physicians are no longer paid per procedure, as ObamaCare envisions. Rather, the lost productivity is a consequence of the more fragmented, less accountable care that results from these schemes.

Once they work for hospitals, physicians change their behavior in two principal ways. Often they see fewer patients and perform fewer timely procedures. Continuity of care also declines, since a physician's responsibilities end when his shift is over. This means reduced incentives for doctors to cover weekend calls, see patients in the ER, squeeze in an office visit, or take phone calls rather than turfing them to nurses. It also means physicians no longer take the time to give detailed

sign-offs as they pass care of patients to other doctors who cover for them on nights, weekends and days off.

Most hospitals exacerbate these strains by measuring the productivity of the physician practices they purchase in "Relative Value Units." This is a formula that Medicare already uses to set doctor-payment rates. RVUs are supposed to measure how much time and physical effort a doctor requires to perform different clinical endeavors.

Medicare assigns each clinical procedure a different RVU and then multiplies this figure by a fixed amount of money to arrive at how much it will pay a doctor for a given task. A routine office visit has an RVU of about 1.68, while removing earwax has one of 1.26. Setting a finger fracture rates a 3.48.

This system misses all of the intangible factors that help gauge the quality and efficiency of the care being delivered. It focuses physicians on the wrong goals for promoting health, such as how well they code charts to capture higher-value "units."

Hospitals are beholden to the RVU system only because that is how they get paid by the government. Data from the Medical Group Management Association shows that physician productivity in these employed relationships, measured simply by RVUs, declines up to 25% compared with independent practices. The Advisory Board Company, a health-care consulting firm, estimates that when hospitals last went on a physician-acquisition binge in the late 1990s, productivity fell by as much as 35%. Those arrangements mostly failed, and the hospitals divested the stakes they had in individual doctor practices. The physicians went back to practicing out of their own offices.

All of this reduced productivity translates into the loss of what should be a critical factor in the effort to offer more health care while containing costs. Yet hospitals aren't buying doctors' practices because they want to reform the delivery of medical care. They are making these purchases to gain local market share and develop monopolies. They are also exploiting an arbitrage opportunity presented by Medicare's billing schemes, which pay more for many services when they are delivered at a hospital instead of an outpatient doctor's office.

This billing structure exists because hospitals are politically favored in Washington. Their mostly unionized workforces give them political power, as does their status as big employers in congressional districts.

ObamaCare pushes this folly largely based on a naive assumption that models that worked well in one community can be made to work everywhere. President Obama has touted "staff models" like the Geisinger Health System in Pennsylvania and the Mayo Clinic in Minnesota that employ doctors and then succeed in reducing costs by closely managing what they do. When integrated delivery networks succeed, they are rarely led by a hospital. ObamaCare seeks to replicate these institutions nationwide, even though their successes had more to do with local traditions and superior management. That's hard to engineer through legislation.

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